VACCINE ADMINISTRATION CONSENT FORM

I _____, authorize Atlanta Pediatric Partners
(Please print your name)

to administer any immunizations as recommended by the American Academy of Pediatrics and the Georgia Department of Health Services, Immunizations Branch to my child

_____ _____
(Please print child's name) *DOB*

- I have read or had explained to me the information about the respective diseases and vaccines
- I had an opportunity to ask questions and any questions were answered satisfactorily
- I believe that I understand the benefits and the risks of these vaccines

Signature of Parent/Legal Guardian

_____

Date _____ / _____ / _____

ATLANTA PEDIATRIC PARTNERS-4579 South Cobb Dr. SE Suite 300 Smyrna, GA. 30080